eyes rite, ltd

Medical History

Please fill out this form and bring it with you to your appointment. Thanks!

Appointment Date:_____ Previous Eye Doctor/Phone: _____

Patient's Name (Please Print): _____ Birth Date: _____ M/F (circle)

Social Security Number: _____ Last Eye Exam? _____

Street Address: _____ City, State, Zip: _____

Best Contact Phone Number: _____ Alternate Phone Number: _____

Email: _____ Emergency Contact: _____

Employer: _____ Occupation: _____

Personal Medical Information: Do you have any problems in these areas? If yes, please check box.

❑ Gastrointestinal ❑ Nervous System ❑ Mental

❑ Ear/Nose/Throat ❑ Genitourinary ❑ Endocrine (glands)

❑ Cardiovascular ❑ Musculoskeletal ❑ Blood/Lymph

❑ Respiratory ❑ Skin ❑ Allergic/Immunologic

❑ Headaches ❑ Surgeries (What type/When?) _____

Any allergic reactions to medications or other substances? ❑ Yes ❑ No Explain: _____

_____

Do you smoke? ❑ Yes ❑ No How much? _____

Do you take medications? ❑ Yes ❑ No Please list names & Dosages: _____

_____

Do you have family history of any of the following? If yes, please check box.

❑ Diabetes ❑ Glaucoma ❑ High Blood Pressure

❑ Macular Degeneration ❑ Retinal Detachment ❑ Cataracts

Please explain any boxes you have checked: _____

_____

Do you have any of the following? If yes, please check box.

❑ Dry Eyes ❑ Eye Surgeries ❑ Wear Glasses

❑ Blurred Vision ❑ Eye Injuries ❑ Wear Contacts (What kind?)

Any eye problems right now? _____ _____ _____

Release of Information

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time of service.

Signature: _____ Date: _____